

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County	<i>Cerro</i>	<i>17427</i>	Registration Dist. No. <i>74</i>	
Village or City	<i>Sykesville</i>	(No. <i>5</i>)	[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <i>John C. Banner</i>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <i>male</i>	4 COLOR OR RACE <i>white</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>married</i> (Write the word)		
6 DATE OF BIRTH <i>unknown</i> (Month) (Day) (Year)				
7 AGE <i>46</i> yrs. <i>unknown</i> mos. <i>unknown</i> ds. OR <i>1</i> day, <i>unknown</i> hrs. <i>unknown</i> min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work <i>unknown</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>unknown</i>				
9 BIRTHPLACE (State or country) <i>Pennsylvania</i>				
PARENTS	10 NAME OF FATHER <i>unknown</i>			
	11 BIRTHPLACE OF FATHER (State or country) <i>unknown</i>			
	12 MAIDEN NAME OF MOTHER <i>unknown</i>			
13 BIRTHPLACE OF MOTHER (State or country) <i>unknown</i>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>S. S. Hosp. History</i> (Address) <i>Sykesville Md.</i>				
15 Filed <i>Oct. 18</i> 191 <i>5</i> <i>Robt Swain</i> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <i>Oct 18</i> 191 <i>5</i> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <i>July 26th</i> 191 <i>5</i> , to <i>Oct 18th</i> 191 <i>5</i> , that I last saw him alive on <i>Oct 18th</i> 191 <i>5</i> , and that death occurred on the date stated above, at <i>5:45</i> a.m.				
The CAUSE OF DEATH * was as follows: <i>General paresis</i> (Duration) <i>unknown</i> yrs. <i>unknown</i> mos. <i>unknown</i> ds.				
Contributory Secondary (Duration) <i>unknown</i> yrs. <i>unknown</i> mos. <i>unknown</i> ds.				
(Signed) <i>John Norfolk Morris</i> , M. D. , 191 <i>5</i> (Address) <i>unknown</i>				
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <i>3</i> yrs. <i>26</i> mos. <i>unknown</i> ds. In the <i>unknown</i> State, <i>unknown</i> yrs. <i>unknown</i> mos. <i>unknown</i> ds. Where was disease contracted, <i>unknown</i> If not at place of death? Former or usual residence <i>unknown</i> .				
19 PLACE OF BURIAL OR REMOVAL <i>Balt Co Md</i>			DATE OF BURIAL <i>Oct 20</i> 191 <i>5</i>	
20 UNDERTAKER <i>Geo R Wear</i>			ADDRESS <i>Sykesville Md</i>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

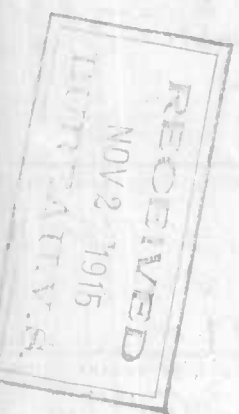
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dobility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trismus," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as *accidental*, *suicidal*, or *homicidal*, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *telum*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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1 PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Carroll.</u>			17428	Registered No. <u>78</u>
Village or City <u>near Derwings</u> (No. <u>104</u>)			St. _____	Ward _____
2 FULL NAME <u>Charles Edwin Barnes.</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>		
6 DATE OF BIRTH <u>Oct 22nd</u> , 1914 (Month) (Day) (Year)				
7 AGE <u>11</u> yrs. <u>10</u> mos. <u>10</u> ds. If LESS than 1 day, ____ hrs. OR ____ min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____				
9 BIRTHPLACE (State or country) <u>Carroll. Co</u>				
PARENTS	10 NAME OF FATHER <u>Charles E. Barnes</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Carroll. Co</u>			
	12 MAIDEN NAME OF MOTHER <u>Lissy Alberta Bloom</u>			
	13 BIRTHPLACE OF MOTHER (State or country) <u>Carroll. Co</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Charles E. Barnes</u> (Address) <u>878 S. Westminster Md.</u>				
15 Filed <u>Oct. 22nd</u> , 1915 <u>Jacob Farmer</u> Local REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Oct 2nd</u> , 1915 (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>Oct 14th</u> , 1915, to <u>Oct 14th</u> , 1915, that I last saw him alive on <u>Oct 14th</u> , 1915, and that death occurred on the date stated above, at <u>8 a. m.</u> , The CAUSE OF DEATH* was as follows: <u>Enter Polio.</u>				
(Duration) ____ yrs. ____ mos. <u>5</u> ds.				
Contributory (Secondary) <u>Convulsion</u>				
(Duration) ____ yrs. ____ mos. <u>1</u> ds.				
(Signed) <u>A. T. Crank</u> , M. D. <u>Oct 2nd</u> , 1915 (Address) <u>St. Mary</u>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Bernezer M. E. Cemetery</u>			DATE OF BURIAL <u>Oct 23rd</u> , 1915	
20 UNDERTAKER <u>E. M. Watz</u>			ADDRESS <u>Winfield Md.</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
NOV 4 1915
BUREAU, V.S.

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1 PLACE OF DEATH

County Carroll 17429Village or City Reese (No. 48) St. Ward STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 23

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Blanch Bell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow
(Write the word)

6 DATE OF BIRTH Sept 24, 1881
(Month) (Day) (Year)

7 AGE 34 yrs. — mos. 22 ds. IT LESS than 1 day, — hrs. OR — min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work. At home
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Charles Chapman

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Luella Potter

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Luella Bell(Address) Westminster

15 Filed Oct 18, 1915 E. L. Skinner
Deputy Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 17, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Aug 10, 1914, to Oct 17, 1915.
that I last saw her alive on Oct 17, 1915

and that death occurred on the date stated above, at 8:30 p. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis(Duration) 2 yrs. 4 mos. — ds.Contributory
Secondary(Duration) — yrs. — mos. — ds.

(Signed) S. Luther Bone, M. D.
Oct. 18, 1915 (Address) Westminster, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL Carrollton DATE OF BURIAL Oct 19, 1915

20 UNDERTAKER Frank C. Shaver ADDRESS Westminster

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

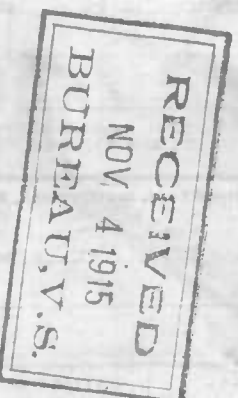
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and usually as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Canall

17430

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 77

Village or City

Hampstead

(No.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Catherine Booss

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDDED
OR DIVORCED
(Write the word)

Widow

6 DATE OF BIRTH

April 17, 1822
(Month) (Day) (Year)

7 AGE

93 yrs. 5 mos. 23 ds.

If LESS than
1 day, hrs.
OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

None

9 BIRTHPLACE

(State or country)

Unknown

10 NAME OF FATHER

Michael Gettier

11 BIRTHPLACE OF FATHER

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edw. G. Tipton

(Address)

Hampstead Md.

15

Filed

Oct 11, 1915

1915

J. M. A. Abbott

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

10 10, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

1915 to 1915

that I last saw him alive on 1915

and that death occurred on the date stated above, at 5 a.m.

The CAUSE OF DEATH was as follows:

Impairment of old age

(Duration) yrs. mos. ds.

Contributory Known body after death
Secondary

(Duration) yrs. mos. ds.

(Signed) D. M. Resh, M. D.

Oct 10, 1915 (Address) Hampstead Md.

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hampstead Md Oct 12, 1915

20 UNDERTAKER

ADDRESS

D. M. Tipton & Son Hampstead Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Mill engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Next return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Tropsey," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trismus," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Prenatal," *septicæmia*, "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as *accidental*, *suicidal*, or *homicidal*, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Carroll 17431 (6A) 1220
Village or City Dyersville (No. Springfree Hospital St.; Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]
2 FULL NAME Patrick Boylan Registration Dist. No. 26

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH October 31st, 1915
(Month) (Day) (Year)

7 AGE 54 yrs. unknown If LESS than 1 day, hrs. OR min. ?
mos. ds.

8 OCCUPATION
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry business, or establishment in which employed (or employer) -

9 BIRTHPLACE (State or country) Ireland

PARENTS

10 NAME OF FATHER Terence Boylan

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Boylan

13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Patrick Boylan
(Address) Westminster Md.

15 Filed Nov-2, 1915 EW Shriver
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 31st, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 26th, 1915, to October 31st, 1915, that I last saw him alive on October 30th, 1915, and that death occurred on the date stated above, at 8:05 A.M.

The CAUSE OF DEATH * was as follows:
Epilepsy
(Duration) 21 yrs. — mos. — ds.
Contributory Acute Meningitis -
Secondary
(Duration) — yrs. — mos. 3 ds.
(Signed) John Norfolk Morris, M. D.
Oct. 31st, 1915 (Address) St. Hosp. Dyersville, Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death 13 yrs. 7 mos. 13 ds. In the unknown State, — yrs. — mos. — ds.
Where was disease contracted, Westminster Md.
If not at place of death?
Former or usual residence Westminster Md.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
St. Johns Cem. Westminster Nov 3, 1915

20 UNDERTAKER ADDRESS
H. Bankard & Son. Westminster

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

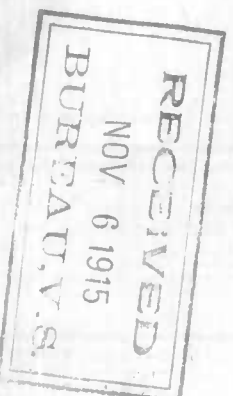
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Form laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal pyæmia," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Carroll

17432

Village or City

Bark Hill

(No.

170

St.

Ward)

Registration Dist. No.

81

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Ellen. Crabbs

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

April 8

(Month)

(Day)

1887 (Year)

7 AGE

78

yrs.

6

mos.

14

ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Carroll Co Ind

PARENTS

10 NAME OF FATHER

Samuel Bowers

11 BIRTHPLACE OF FATHER

(State or country)

Carroll Co Ind

12 MAIDEN NAME OF MOTHER

Nancy Wilson

13 BIRTHPLACE OF MOTHER

(State or country)

Carroll Co Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles E. Crabbs

(Address)

Union Bridge Ind

15

Filed

10/23

1915

T. H. L. L. L.

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct. 22

(Month)

(Day)

1915 (Year)

17

I HEREBY CERTIFY, That I attended deceased from

July 20, 1915, to Oct. 22, 1915.

that I last saw her alive on Oct. 21, 1915.

and that death occurred on the date stated above, at 5.30 P. M.

The CAUSE OF DEATH* was as follows:

Myo. carditis

(Duration) 4 yrs. + mos. + ds.

Contributory
Secondary

Chronic Int. nephritis

(Duration) + yrs. + mos. + ds.

(Signed)

J. H. L. L. L., M. D.

Oct 23, 1915 (Address) Union Bridge

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt Union Ind Oct 25, 1915

20 UNDERTAKER

ADDRESS

C. O. Fuso & Son Taneytown Ind

If more blanks are needed, address State Registrar, C. E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.¹

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
NOV 4 1915
BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Carroll

17433

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 75Village or City Melrose (No. _____)

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Franklin T. Crumrine

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH

June 25, 1844
(Month) (Day) (Year)

7 AGE

71 yrs. 3 mos. 16 ds. IF LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work. Retired Farmer
(b) General nature of industry, business, or establishment to which employed (or employer)

9 BIRTHPLACE
(State or country)Carroll Co. Md.

PARENTS

10 NAME OF FATHER

Wm Crumrine11 BIRTHPLACE OF FATHER
(State or country)Carroll Co. Md.

12 MAIDEN NAME OF MOTHER

Anna M. Steffy13 BIRTHPLACE OF MOTHER
(State or country)Carroll Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward Crumrine(Address) Melrose Md.

15

Filed 10/12, 1915J. O. Baltoz

REGISTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 11, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1915, to Oct 11, 1915.that I last saw him alive on Oct 11, 1915.and that death occurred on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy(Duration) 6 hours yrs. ____ mos. ____ ds.Contributory
(Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. H. Sherman, M. D.
Oct 11, 1915 (Address) Manchester Ind.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. to the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Davids York Ind. 10-14, 1915

20 UNDERTAKER

ADDRESS

W. L. E. Bergman Manchester Ind.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 10 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
NOV 5 1915
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Cannell

17434

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. 83Village or City Woodline (No. 64) St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Annie Daywalt.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow
(Write the word)6 DATE OF BIRTH Jan not known 1844
(Month) (Day) (Year)7 AGE 71 yrs. 9 mos. ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Retired(b) General nature of industry, business, or establishment in which employed (or employer) Not any9 BIRTHPLACE
(State or country)Maryland

10 NAME OF FATHER

Thomas Brass.

PARENTS

11 BIRTHPLACE OF FATHER
(State or country)Not known

12 MAIDEN NAME OF MOTHER

Not known13 BIRTHPLACE OF MOTHER
(State or country)Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Adira G. KinnellP. J. A. Woodline, Md.
(Address)15 Filed Oct 8, 1915 J. William Glennon
J. Leeping REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct-7th, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Oct-6th, 1915, to Oct-6th, 1915;
that I last saw her alive on Oct-6th, 1915.and that death occurred on the date stated above, at 11 a m.
The CAUSE OF DEATH* was as follows:Apoplexy.(Duration) yrs. 2 mos. ds.Contributory
(Secondary)(Duration) yrs. mos. ds.

(Signed)

Oct-7th, 1915 (Address) St. Mary's Cemetery, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Mary's Cemetery, Hampshire Oct-9th, 1915

20 UNDERTAKER

ADDRESS

Co. M. Brady Winfield, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

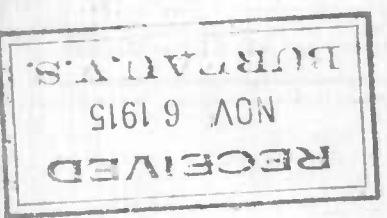
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Carroll

17435

(9)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 8DVillage or City New Windsor (No. _____)

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John D. Dowsary

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored5 SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word)Single

6 DATE OF BIRTH

Oct 1, 1915
(Month) (Day) (Year)

7 AGE

0 yrs. 0 mos. 0 ds.If LESS than
1 day, 0 hrs.
OR 0 min. ?

OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Carroll Co

PARENTS

10 NAME OF FATHER

Martin J. Dowsary

11 BIRTHPLACE OF FATHER

(State or country)

Fredrick Co

12 MAIDEN NAME OF MOTHER

Bessie A. Milberg

13 BIRTHPLACE OF MOTHER

(State or country)

Carroll Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Martin J. Dowsary, Father

(Address)

New Windsor, Md.

15

Filed

10/2

1915

J. Edward West
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 1, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

1915, to 1915,

that I last saw him alive on 1915,

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH * was as follows:

Still born
Anti partum hemorrhage
+ separation of placenta. (Duration) _____ yrs. _____ mos. _____ ds.Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

D. F. H. Legg, M. D.Oct 1, 1915 (Address) Union Bridge and

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds.

In the State, _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt Olive10-2, 1915

20 UNDERTAKER

ADDRESS

F. J. ShonierUnion Bridge
Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

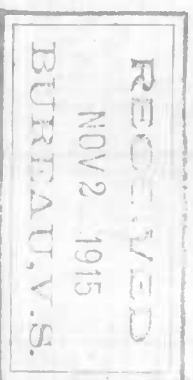
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Carroll, Ind. 17486Village or City in Hamfstead (No. _____)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 77

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Myrtle Clay Elseroad

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH October 11, 1915
(Month) (Day) (Year)

7 AGE Still born, (6 mo. foetus) If LESS than 1 day, ____ hrs. OR ____ min. ?
____ yrs. ____ mos. ____ ds.

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Carroll Co. Ind.

PARENTS
10 NAME OF FATHER Walter Elseroad
11 BIRTHPLACE OF FATHER (State or country) Carroll, Ind.
12 MAIDEN NAME OF MOTHER Myrtle Clay Beatty
13 BIRTHPLACE OF MOTHER (State or country) Balto City, Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Myrtle Clay Elseroad
(Address) Hamfstead

15 Oct 20 Filed or over, 1915 P. I. Hamfstead REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Still born Oct. 11, 1915
Spudge died a day or so later (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw h_____ alive on _____, 191____,

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH * was as follows:

Unknown - Probably some pathological condition of mother
(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
Secondary

(Signed) Cyril Elmo Fowler M. D.
10/11, 1915 (Address) uppers, Ind.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State, ____ yrs. ____ mos. ____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Wesley M. E. Cemetery DATE OF BURIAL Oct. 11, 1915

20 UNDERTAKER P. I. Hamfstead ADDRESS Hamfstead

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Uterinoma*, *Sarcoma*, etc., etc. (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Meninges*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 yrs.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dibility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Prenatal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Rocher wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
NOV 9 1915
TREATY, V. S.

see letter under
Murray Dec. 17, 1915

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Carroll 17437 (6)
Village or City Sparksville (No. Springfield St. Apt St. Ward)
2 FULL NAME Annie M. Flack
Registration Dist. No. 74
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word)

6 DATE OF BIRTH unknown, 1 (Month) (Day) (Year)

7 AGE 42 yrs. — mos. — ds. If LESS than 1 day, — hrs. OR — min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House work
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ohio

10 NAME OF FATHER Jacob Voght

11 BIRTHPLACE OF FATHER (State or country) Pa

12 MAIDEN NAME OF MOTHER Hannah Goldner

13 BIRTHPLACE OF MOTHER (State or country) Ohio

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert Reards

(Address) Springfield St.

15 Filed Oct. 24, 1915 Robert Reards

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 24, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1915, to Oct 24, 1915,

that I last saw her alive on Oct 28, 1915,

and that death occurred on the date stated above, at 3:02 m.

The CAUSE OF DEATH * was as follows:

Acute dilatation of the Heart
(Duration) yrs. — mos. — ds.

Contributory Organic Brain Disease
Secondary

(Signed) H. S. Underhill, M. D.
Oct 24, 1915 (Address) Sparksville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. 1 mos. — ds. In the unknown State, — yrs. — mos. — ds.

Where was disease contracted, If not at place of death? unknown

Former or usual residence Relay, Md.

19 PLACE OF BURIAL OR REMOVAL Balto City Md DATE OF BURIAL Oct 24, 1915

20 UNDERTAKER Geo T. Wear ADDRESS Sparksville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

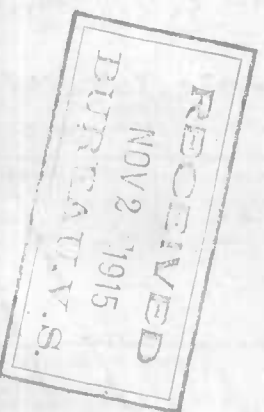
[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County Carroll 17438

Village or City New Windsor (No. 39)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 80

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Lennis A. Fogle

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED widowed
(Write the word)

6 DATE OF BIRTH

May 8, 1841
(Month) (Day) (Year)

7 AGE

74 yrs. 5 mos. 17 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Rail Fence maker
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Frederick Co

PARENTS

10 NAME OF FATHER

Jacob Fogle

11 BIRTHPLACE OF FATHER

(State or country) Unknown

12 M maiden NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D. Oden Fogle Son

(Address) Union Bridge, R. 7 D.

15

Filed Oct 26, 1915 J. E. Edwards
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 25, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

have not attended recently, 1915

that I last saw him alive on _____, 1915

and that death occurred on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH was as follows:

Epithelioma of lower lip
with general metastasis
(Duration) 8 yrs. 0 mos. 0 ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Legg, M. D.

Oct 25, 1915 (Address) Union Bridge

*State the DISEASE CAUSING DEATH, or, in deaths from Violent CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State, _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Union Bridge Cemetery Oct 27, 1915

20 UNDERTAKER

ADDRESS

P. C. Groenmich Union Bridge

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

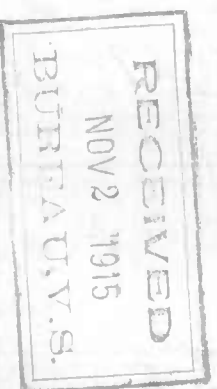
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Trocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Clerk," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Muscles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *telanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Carroll

17439

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

79

Village or City

Keymar

(No.

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mary Foreman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Widowed

6 DATE OF BIRTH

Oct 3

(Month)

(Day)

1821
(Year)

7 AGE

94

yrs.

0

mos.

28

ds.

It LESS than
1 day, ... hrs.
OR ... min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Frederick Co

PARENTS

10 NAME OF FATHER

Andrew Boston

11 BIRTHPLACE OF FATHER

(State or country)

Frederick Co Ind

12 MAIDEN NAME OF MOTHER

Barbary Fox

13 BIRTHPLACE OF MOTHER

(State or country)

Frederick Co Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sarah Koons

(Address)

Keymar Ind

15

Filed

Oct 31

1915

E. M. Fick

Deputy Local

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 31st

1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Oct 10th 1915, to Oct 21st 1915.

that I last saw him alive on

Oct 21st 1915.

and that death occurred on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

general dropsy
exhaustion from age & disease
W.C.

(Duration)

yrs.

mos.

ds.

Contributory
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

J. B. B. B.

M. D.

Oct 31, 1915

(Address)

Tanytown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

It not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Haugh's Church

Nov 2

1915

20 UNDERTAKER

ADDRESS

E. O. Foss & Son Tanytown Ind

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

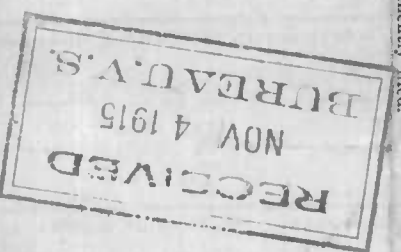
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

17440

County CarrollSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 75Village or City Manchester (No.)

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mary Alice Froch

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word)
------------------------	---------------------------------	--

6 DATE OF BIRTH

Aug 15, 1915
(Month) (Day) (Year)

7 AGE

yrs. 2 mos. 11 ds. OR LESS than 1 day.....hrs. OR.....mo.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9 BIRTHPLACE
(State or country)Carroll Co. Md.

PARENTS

10 NAME OF FATHER

Herbert Froch11 BIRTHPLACE OF FATHER
(State or country)Carroll Co Md

12 MAIDEN NAME OF MOTHER

Grace Helen Yinzling13 BIRTHPLACE OF MOTHER
(State or country)Carroll Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Grace H Yinzling

(Address)

Hampstead Md.

15

Filed

10/28, 1915, J. G. Baltzer

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 26, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Oct 20, 1915, to Oct 26, 1915,that I last saw her alive on Oct 25, 1915and that death occurred on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. A. Sherman

M. D.

Oct 27, 1915(Address) Manchester Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL

Manchester Md.

DATE OF BURIAL

10-28, 1915

20 UNDERTAKER

A. F. Beigman

ADDRESS

Manchester Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Carroll</u>		17441		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>near Winfield</u>		(No. <u>64</u>)		Registration Dist. No. <u>83</u>	
2 FULL NAME <u>Eliza Mallow Goodwin</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widow</u> (Write the word)			
6 DATE OF BIRTH <u>June 11, 1839</u> (Month) (Day) (Year)					
7 AGE <u>76</u> yrs. <u>4</u> mos. <u>14</u> ds. If LESS than 1 day, hrs. OR min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>At home</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS	10 NAME OF FATHER <u>Joshua S. Porter (deceased)</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>				
	12 MAIDEN NAME OF MOTHER <u>Annie W. Wilson (deceased)</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Alice B. Hancock</u> <u>B. F. D. #3 Woodbine, Md.</u> (Address)					
15 Filed <u>Oct 21</u> , 1915 <u>M. Glennan</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Oct. 25</u> , 1915 (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Oct 3</u> , 1915, to <u>Oct 25</u> , 1915, that I last saw her alive on <u>Oct 24</u> , 1915, and that death occurred on the date stated above, at <u>9:45 P.M.</u> The CAUSE OF DEATH* was as follows: <u>Progressive Paralysis</u> (Duration) <u>22</u> yrs. <u>22</u> mos. <u>22</u> ds. Contributory <u>Cerebral Hemorrhage</u> Secondary <u>arterio-sclerosis</u> (Duration) <u>10</u> yrs. <u>10</u> mos. <u>10</u> ds. (Signed) <u>E. D. Brink</u> , M. D. <u>Oct 26, 1915</u> (Address) <u>Woodbine</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u> </u> yrs. <u> </u> mos. <u> </u> ds. In the State <u> </u> yrs. <u> </u> mos. <u> </u> ds. Where was disease contracted, if not at place of death? Former or usual residence <u> </u>					
19 PLACE OF BURIAL OR REMOVAL <u>Elmwood M.E. Cemetery</u>				DATE OF BURIAL <u>Oct 28</u> , 1915	
20 UNDERTAKER <u>L. M. Wootch</u>				ADDRESS <u>Winfield Md.</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Tracma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH <i>Harrell</i>			STATE OF MARYLAND CERTIFICATE OF DEATH		
County <i>Harrell</i>			Registration Dist. No. <i>81</i>		
Village or City <i>Union Bridge</i> (No. <i>17442</i>)			St.; Ward		
2 FULL NAME <i>John H Green</i>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i> <i>Black</i>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <i>Married</i> (Write the word)			
6 DATE OF BIRTH <i>4 - 20 - 1845</i> (Month) (Day) (Year)					
7 AGE <i>70</i> yrs. <i>6</i> mos. <i>3</i> ds. If LESS than 1 day... hrs. OR... min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <i>Laborer</i> (b) General nature of industry business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <i>Montgomery Co Md</i>					
PARENTS					
10 NAME OF FATHER <i>Joshua Green</i>					
11 BIRTHPLACE OF FATHER (State or country) <i>Maryland</i>					
12 MAIDEN NAME OF MOTHER <i>Eliza Hammett</i>					
13 BIRTHPLACE OF MOTHER (State or country) <i>Maryland</i>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Mrs. John H Green</i> (Address) <i>Union Bridge Md</i>					
15 Filed <i>10/26</i> , 191 <i>5</i> <i>J. Leslie Norris</i> Deputy REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <i>Oct 23</i> , 191 <i>5</i> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <i>Oct 19</i> , 191 <i>5</i> , to <i>Oct 23</i> , 191 <i>5</i> , that I last saw him alive on <i>Oct 19</i> , 191 <i>5</i> , and that death occurred on the date stated above, at <i>4:30</i> a.m. The CAUSE OF DEATH * was as follows: <i>Arterio Sclerosis</i> (Duration) <i>4</i> yrs. mos. ds.					
Contributory Secondary (Duration) yrs. mos. ds.					
(Signed) <i>J. H. Legg, M. D.</i> <i>Oct. 25</i> , 191 <i>5</i> (Address) <i>Union Bridge Md</i>					
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State, yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <i>Wm. Joy Green</i>				DATE OF BURIAL <i>10-26</i> , 191 <i>5</i>	
20 UNDERTAKER <i>F. J. Shriver</i>				ADDRESS <i>Union Bridge Md</i>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

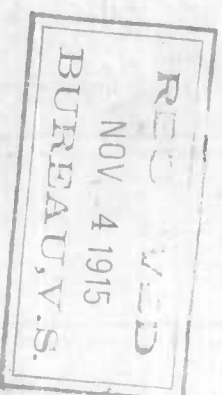
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first; the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by corbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

17448

County CarrollVillage or City Saylorsville (No. 142)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 78

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Henrietta Green

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow
(Write the word)

6 DATE OF BIRTH Oct. 25th, 1886.
(Month) (Day) (Year)

7 AGE 88 yrs. 11 mos. 28 ds. It LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country) Maryland

PARENTS

10 NAME OF FATHER Benjamin Spurr

11 BIRTHPLACE OF FATHER
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Rachael Williams

13 BIRTHPLACE OF MOTHER
(State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos. J. GulesR. F. (Address) Wm. A. G. G. G. G.

15 Filed Oct. 4, 1915 Wm. A. G. G. G.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 3rd, 1915.
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sep. 13th, 1915, to Oct. 2nd, 1915.
that I last saw him alive on Oct. 1st, 1915.

and that death occurred on the date stated above, at 4:00 P. m.

The CAUSE OF DEATH* was as follows:

Gangrene of leg.

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) A. T. G. G. G., M. D.
Oct 3rd, 1915. (Address) Wm. A. G. G. G.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bethany M. & S. Cemetery Oct. 5th, 1915

20 UNDERTAKER ADDRESS
B. M. Math Winfield

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
NOV 4 1915
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Carroll

17444 1220

Village or City Westminster (No. 175)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 70

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Robert Hampton

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Exact date unknown
(Month) (Day) (Year)

7 AGE Apparent age 24 If LESS than
1 day, hrs. OR min. ?
yrs. mos. ds.

8 OCCUPATION

(a) Trade, profession, or particular kind of work. Structural Iron worker
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)Wisconsin

PARENTS

10 NAME OF FATHER

Unknown11 BIRTHPLACE OF FATHER
(State or country)Unknown

12 MAIDEN NAME OF MOTHER

Unknown13 BIRTHPLACE OF MOTHER
(State or country)Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Clarke

(Address)

Foruman - Lackawanna Bridge Co
Buffalo N.Y.

15

Filed

Oct-24-1915 C. W. Shriver

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 23rd, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 23rd, 1915, to Oct 23rd, 1915.

that I last saw him alive on Oct. 23rd, 1915

and that death occurred on the date stated above, at 8:45 A.m.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage -
due to crushing blow from
steel beam - (Bridge girders)
(Duration) 15 minutes

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) S. J. L. Bare, M. D.
Oct 23rd, 1915 (Address) Westminster, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cato - Wisconsin Oct 24th, 1915

20 UNDERTAKER

ADDRESS

Frank C. Shriver Westminster

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accidental*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
NOV 6 1915
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

17445

County CarrollSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 74Village or City Sykesville, Md. (No. Springfield State Hospital) Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Cecelia Hussin

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(Write the word)

6 DATE OF BIRTH Unknown, 1834
(Month) (Day) (Year)

7 AGE 81 yrs. Unknown ds. 1 day, Unknown hrs. OR Unknown min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ireland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records(Address) S. S. Hosp. Sykesville, Md.

15 Filed Oct. 7 6/5 1915 Robert L. Swain

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 25, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1915, to Oct. 25, 1915,

that I last saw him alive on Oct. 25, 1915,

and that death occurred on the date stated above, at 1:05 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Pancreatic malacia
Nephritis (Duration) 3 yrs. Unknown mos. Unknown ds.

Contributory Mitral Regurgitation
Secondary (Duration) Unknown mos. Unknown ds.

(Signed) John L. Withered, M. D.
Oct. 25, 1915 (Address) S. S. Hosp. Sykesville, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 6 yrs. 5 mos. 13 ds. in the Unknown State, Unknown mos. Unknown ds.

Where was disease contracted, If not at place of death?

Former or usual residence Bay View Hosp. since 1887

19 PLACE OF BURIAL OR REMOVAL Prosp. Cemetery DATE OF BURIAL Oct. 26, 1915

20 UNDERTAKER Jas. R. New ADDRESS Sykesville Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

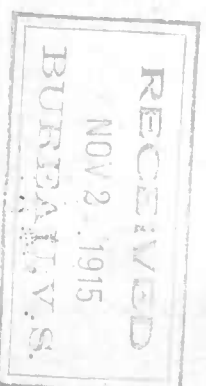
[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Carroll Co.

17446

(79)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 70Village or City near Soneytown (No. _____)

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Catherine Elizabeth Kniipple

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE, MARRIED, WIDOWED, OR DIVORCED
(Write the word)Widowed

6 DATE OF BIRTH

June291832

(Month)

(Day)

(Year)

7 AGE

83313ds.or LESS than
1 day, _____ hrs.
OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Carroll Co., Md.

PARENTS

10 NAME OF FATHER

Daniel Hamann

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Elizabeth Angell

13 BIRTHPLACE OF MOTHER

(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. J. Hamann

(Address)

Keymar, Md.

15

Filed

Oct 13, 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 121915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from
Aug 6th, 1915, to Oct 11, 1915,that I last saw her alive on Oct 11, 1915,and that death occurred on the date stated above, at 9-a- m.

The CAUSE OF DEATH* was as follows:

Heart Insufficiency(Duration) 2 yrs. _____ mos. _____ ds.Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Oct 11, 1915 (Address) Saneytown, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lutheran Cem. SaneytownOct 14, 1915

20 UNDERTAKER

ADDRESS

C. O. Fuss Bon Saneytown, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

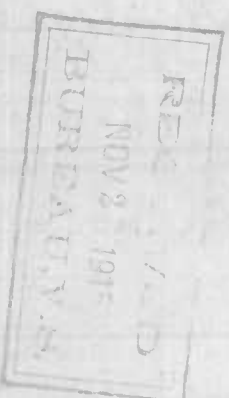
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scalic," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL SEPTICÆMIA," "PERIPERAL PERITONITIS," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Carroll

17447

(91)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 74Village or City Lylesville (No. Springfield Hospital St.; Ward)

[If death occurred in a hospital or institution, give his NAME instead of street and number.]

2 FULL NAME Albert F. Miles

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)6 DATE OF BIRTH Unknown, 1833
(Month) (Day) (Year)7 AGE 82 yrs. unknown mos. ds. If LESS than 1 day, hrs. OR min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) Montgomery Co. Md.10 NAME OF FATHER Charles Miles11 BIRTHPLACE OF FATHER (State or country) Montgomery Co.12 M maiden NAME OF MOTHER Almeta Mobley13 BIRTHPLACE OF MOTHER (State or country) Fred Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William F. Miles(Address) Mt Airy, Md. R.F.D.15 Filed Oct. 17, 1915 Robert L. Swann

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 17th, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from July 26th, 1915, to October 17th, 1915, that I last saw him alive on October 16th, 1915, and that death occurred on the date stated above, at 12:10 P. m.

The CAUSE OF DEATH * was as follows:

Broncho-PneumoniaContributory Senile Arterio Sclerosis
(Duration) yrs. mos. 3 ds.
Secondary unknown
(Duration) yrs. mos. ds.(Signed) John Norfolk Morris, M. D.
, 191 (Address) 55 N. Hop. Lylesville, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 8 mos. 20 ds. In the State, 82 yrs. - mos. - ds.

Where was disease contracted, If not at place of death?

Former or usual residence Mt Airy, Md. R.F.D.19 PLACE OF BURIAL OR REMOVAL Howard Chap. Cem. DATE OF BURIAL Oct. 19, 191520 UNDERTAKER B. W. Bowman ADDRESS Mt Airy, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

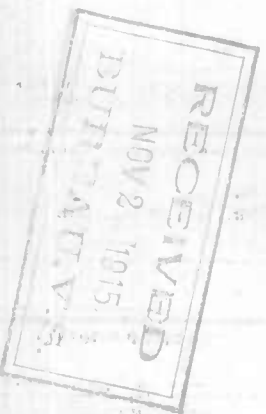
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *neuri-*

gæ, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tramia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *leuæmia*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Carroll

17448216-

(45)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 76Village or City Westminster (No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Ann Matilda Miller

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow
(Write the word)

6 DATE OF BIRTH Feb 7, 1883
(Month) (Day) (Year)

7 AGE 82 yrs. 7 mos. 28 ds. OR 1 day, hrs. 28 min. ?
If LESS than 1 day, hrs. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Abraham Towle

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan Banghman

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas F Miller(Address) Westminster

15 Filed Oct-6-1915 E. M. Shriver
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 6, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from June 25th 1915, to Oct 6th, 1915.

that I last saw h er alive on Oct 6th, 1915.

and that death occurred on the date stated above, at 9⁴⁵ a.m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Thigh

Contributory Penility (Duration) 5 yrs. mos. ds.
Secondary

(Signed) Levin Woodward M. D.
Oct 6th 1915 (Address) Westminster

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; add (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Baltimore DATE OF BURIAL Oct 8, 1915

20 UNDERTAKER Frank C Shaver ADDRESS Westminster

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

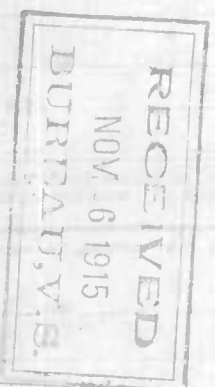
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thein," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital"), "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

17449

County

Carroll

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

74

Village or City

Sykesville

(No.

Springfield State Hosp.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mary E. Miller

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

Unknown, 1845
(Month) (Day) (Year)

7 AGE

70 yrs. Unknown ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

9 BIRTHPLACE

(State or country)

Unknown

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Records

(Address)

S.S. Hosp. Sykesville, Md

15

Filed

Oct. 11, 1915

R. L. Egan

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

October 10, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

June 6th, 1915, to October 10, 1915,

that I last saw her alive on October 10, 1915,

and that death occurred on the date stated above, at 6¹⁵ P.M.

The CAUSE OF DEATH * was as follows:

Pneumonia

(Duration) yrs. mos. 7 ds.

Contributory

Chronic Valvular Heart Disease

Secondary

(Duration) Unknown ds.

(Signed)

John L. Weathered

M. O.

Oct 10, 1915 (Address) S.S. Hosp., Sykesville, Md

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 3 mos. 18 ds.

In the State, Unknown ds.

Where was disease contracted, If not at place of death?

Former or usual residence "Bay View" Hospital, Baltimore

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore Md Oct 12, 1915

20 UNDERTAKER

ADDRESS

Eas R. Hux Sykesville Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

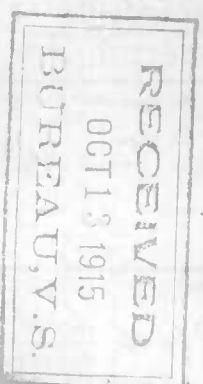
[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, menin-*

ges, peritonaeum, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Muscles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds; Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

17450

County

Carroll

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

74

Village or City

Sykesville

(No.)

Springfield State Hospital

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Annie Myers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word)

Widow

6 DATE OF BIRTH

Unknown, 1850
(Month) (Day) (Year)

7 AGE

65 yrs. Unknown
us. OR min. ?If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work

Institution for past 30 yrs

(b) General nature of industry
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

Germany

10 NAME OF
FATHER

Unknown

11 BIRTHPLACE
OF FATHER

(State or country)

Unknown

12 MAIDEN NAME
OF MOTHER

Unknown

13 BIRTHPLACE
OF MOTHER

(State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Records

(Address)

S.S. Hosp. Sykesville, Md

15

Filed

Oct. 18, 1915

W. L. Swann

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

October 18, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 17, 1915, to October 18, 1915,

that I last saw him alive on October 18, 1915,

and that death occurred on the date stated above, at 3²² p.m.

The CAUSE OF DEATH * was as follows:

Bronchitis - Pneumonia

(Duration) yrs. mos. 17 ds.

Contributory

Arterio - Sclerosis

Secondary

(Duration) yrs. mos. ds.

(Signed)

J. L. Withersed

M. D.

Oct. 18, 1915

(Address)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place
of death yrs. 1 mos. 1 ds.In the
State, Unknown ds.Where was disease contracted,
if not at place of death?Former or
usual residence

Bay View Hospital

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore Co

Oct. 20, 1915

20 UNDERTAKER

ADDRESS

Geo R Weir Sykesville

Md

If more blanks are needed, address State Registrar, 18 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

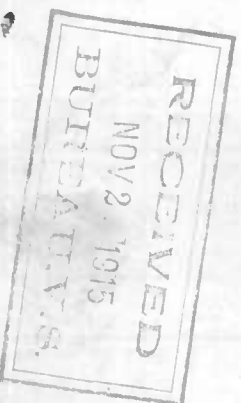
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Carroll

17451

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 82Village or City Ridgeville

(No. _____)

St.; _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mrs. Barbara E. Norwood

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Widow

6 DATE OF BIRTH

1 5 1828
(Month) (Day) (Year)

7 AGE

87 yrs. 8 mos. 26 ds.If LESS than
1 day, _____ hrs.
OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Samuel Ryan

11 BIRTHPLACE OF FATHER

Maryland

12 MAIDEN NAME OF MOTHER

Eva Kemp

13 BIRTHPLACE OF MOTHER

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. B. Norwood

(Address)

Ridgeville Md

15

Filed 9-2

, 1915

R. L. Brunkles

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

October 1st, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from August 4th, 1915, to October 1st, 1915,that I last saw her alive on Friday Oct. 1st, 1915,and that death occurred on the date stated above, at 8 P. m.

The CAUSE OF DEATH * was as follows:

Chronic Valvular Heart DiseaseContributory
Secondaryunknown
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

October 2nd, 1915 (Address) Mt. Airy, Md
J. Albert Rice, M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State, _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hempstead Cem 10-3, 1915

20 UNDERTAKER

ADDRESS

Blut Borman Mt Airy Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

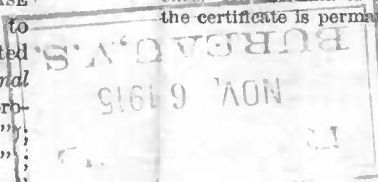
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Crocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Carroll

17452

(67)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 74Village or City Lykesville (No. Springfield Hospital St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Frank R. O'Brien (Bryan)?

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Unknown, 1859
(Month) (Day) (Year)

7 AGE 56 yrs. Unknown mos. Unknown ds. If LESS than 1 day, Unknown hrs. OR Unknown min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Mechanic
(b) General nature of industry business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) md

PARENTS

10 NAME OF FATHER Patrick O'Brien

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Frances Westley

13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Emma A. O'Brien

(Address) 1013 Wilcox St. Balto.-md

15 Filed Oct. 5, 1915 J. P. K. Luxon

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 7th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 26th, 1915, to October 7th, 1915, that I last saw him alive on October 7th, 1915, and that death occurred on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH * was as follows:

General paresis

Unknown
(Duration) Unknown yrs. Unknown mos. Unknown ds.

Contributory —
Secondary —

(Signed) John Norfolk Morris, M. D.
Oct. 7th, 1915 (Address) PS Hospital, Lykesville, md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 3 yrs. 16 mos. 16 ds. In the 56 yrs. — mos. — ds. State, md.

Where was disease contracted, Unknown

If not at place of death? Unknown
Former or usual residence Balto. md.

19 PLACE OF BURIAL OR REMOVAL Holly Cross, Balto. md. DATE OF BURIAL Oct. 10, 1915

20 UNDERTAKER William Cook ADDRESS 582 E. Math

✓ If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

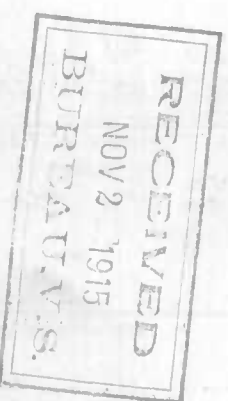
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Crocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Form laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*, *Chronic valvular heart disease*, *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tranmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County Carroll

17453

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 78

Village or City None (No. 104) St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Orpha Catharine Penn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
6 DATE OF BIRTH <u>Nov 11th</u> , 191 <u>5</u> (Month) (Day) (Year)		
7 AGE <u>4</u> yrs. <u>6</u> mos. <u>20</u> ds.		If LESS than 1 day, hrs. OR min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u> </u> (b) General nature of industry, business, or establishment in which employed (or employer) <u> </u>		
9 BIRTHPLACE (State or country) <u>Carroll Co</u>		
PARENTS	10 NAME OF FATHER <u>Charles S. Penn</u>	
	11 BIRTHPLACE OF FATHER (State or country) <u>Carroll Co</u>	
	12 MAIDEN NAME OF MOTHER <u>Emily B. Gennell</u>	
	13 BIRTHPLACE OF MOTHER (State or country) <u>Carroll Co</u>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Heather

(Address) Mt Airy

15 Filed Oct 2, 1915 Jacob Larum
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 1st, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sep 30th, 1915, to Sep 30th, 1915, that I last saw her alive on Sep 30th, 1915, and that death occurred on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Cholera Infusionalis

(Duration) yrs. mos. 3 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) A. J. Gennell, M. D.
Oct 7th, 1915 (Address) Mt Airy

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Union Bethel Cemetery Oct 3rd, 1915

20 UNDERTAKER

ADDRESS

James Pickett & Son Woodlawn, Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Paralysis," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
NOV. 4 1915
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Carroll

17454

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 74Village or City Fryesville (No. Springfield Hospital St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME James H. Pickett

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word)6 DATE OF BIRTH December 9th, 1835
(Month) (Day) (Year)7 AGE 79 yrs. 9 mos. 23 ds. If LESS than 1 day, hrs. OR min.?8 OCCUPATION
(a) Trade, profession, or particular kind of work Railroad Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) Carroll Co.10 NAME OF FATHER Russ B. Pickett11 BIRTHPLACE OF FATHER (State or country) Carroll Co.12 MAIDEN NAME OF MOTHER Rachel Tucker13 BIRTHPLACE OF MOTHER (State or country) Carroll Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Pickett(Address) Mt Airy, Md RFB#615 Filed Oct. 2, 1915 H. H. Swann

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 2nd, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from July 26th, 1915, to October 2nd, 1915, that I last saw him alive on October 2nd, 1915, and that death occurred on the date stated above, at 2:05 P.M.

The CAUSE OF DEATH * was as follows:

General Arterio-sclerosis -
unknown
(Duration) yrs. mos. ds.
Contributory Epithelioma of Face and
Secondary about 4 years
(Duration) yrs. mos. ds.
(Signed) John Norfolk Morris, M. D.
Oct. 2nd, 1915 (Address) S. S. Hospital, Frysburg, Md

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 5 mos. 29 ds. In the State, 79 yrs. 9 mos. 23 ds.Where was disease contracted, Carroll Co. Md -If not at place of death? Carroll Co. Md -
Former or usual residence19 PLACE OF BURIAL OR REMOVAL Poplar Springs Cem DATE OF BURIAL 10-4, 191520 UNDERTAKER Blut Brouman ADDRESS Mt Airy Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

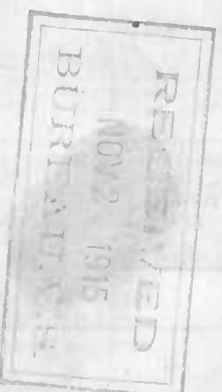
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Trocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Tailor," etc., without more precise specification as *Day laborer*, *Furn laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tranquity," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths, state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Carroll 17455 1221
Village or City Westminster (No. 79) St.; Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]
2 FULL NAME Charles S Roof

Registration Dist. No. 76

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single
6 DATE OF BIRTH Sept 28, 1844.
(Month) (Day) (Year)
7 AGE 71 yrs. 29 mos. 29 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work. Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Post office work

9 BIRTHPLACE (State or country) Maryland

PARENTS
10 NAME OF FATHER Josiah Roof
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Elizabeth Shaeffer
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sallie Roof
(Address) Westminster

15 Filed Oct-28, 1915 E. W. Shuman
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 22, 1915.
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from mid Sep month 1915, to day of death 1915.
that I last saw him alive on Oct. 26, 1915.

and that death occurred on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

He had asthma and dropsy

(Duration) 1 yrs. mos. ds.
Contributor Primary
Secondary

(Signed) Jos. H. Billingslee, M. D.
Oct. 27, 1915. (Address) Westminster, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Westminster DATE OF BURIAL Oct 28, 1915

20 UNDERTAKER Frank C. Shaner ADDRESS Westminster

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

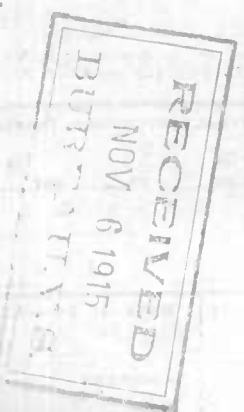
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubercular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Con-fusional," "Scullie," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæ-mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—acci-dent*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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PLACE OF DEATH

County

Carroll

17456

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

75

Village or City

Melrose

(No.

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME

Rebecca Shaffer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH

Dec

15

1825

(Month)

(Day)

(Year)

7 AGE

89

yrs.

9

mos.

27

ds.

If LESS than 1 day, hrs. OR mo. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Pennsylvania

PARENTS

10 NAME OF FATHER

Henry Stambaugh

11 BIRTHPLACE OF FATHER (State or country)

Pennsylvania

12 MAIDEN NAME OF MOTHER

Katherine Lucabagh

13 BIRTHPLACE OF MOTHER (State or country)

Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. J. C. Danner

(Address)

Manchester Md

15

Filed

10/13, 1915

J. A. Baltzer

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

October

12th

1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

, 191

to

, 191

that I last saw him alive on

, 191

and that death occurred on the date stated above, at

5 P. m.

The CAUSE OF DEATH* was as follows:

Died very suddenly

Arterio-sclerosis

(Duration)

yrs.

mos.

ds.

Contributory (Secondary)

Myocarditis

(Duration)

yrs.

mos.

ds.

(Signed)

W. R. S. Danner

, M. D.

(Date)

Oct 13th, 1915

(Address)

Manchester, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

Manchester Md

DATE OF BURIAL

10-16, 1915

20 UNDERTAKER

ADDRESS

W. L. Bergman Manchester

Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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RECEIVED
NOV. 5 1915
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Carroll Co. 17457Village or City Saneytown (No. 79) St. Ward

2 FULL NAME

Barinda Adelaide ShoemakerSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 70

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH Apr. 23, 1848
(Month) (Day) (Year)

7 AGE 67 yrs. 5 mos. 10 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Carroll Co., Md.

10 NAME OF FATHER Abram H. Hess

11 BIRTHPLACE OF FATHER (State or country) Carroll Co., Md.

12 MAIDEN NAME OF MOTHER Sarilla Fesser

13 BIRTHPLACE OF MOTHER (State or country) Carroll Co., Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Barina Fringer

(Address) Saneytown, Md.

15 Filed Oct 5-1848 W.B. Hagan Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 3, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1915 to Oct 3, 1915, that I last saw her alive on Oct 3, 1915

and that death occurred on the date stated above, at 6.15 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(Duration) 1 1/2 hours yrs. mos. ds.

Contributory Heart disease
Secondary

(Signed) P. H. Seis, M. D.

10/4, 1915. (Address) Saneytown, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Lutheran Cem. Saneytown DATE OF BURIAL 10/6, 1915

20 UNDERTAKER B.O. Fuss & Son ADDRESS Saneytown, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

Med. Exam. 10 October

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

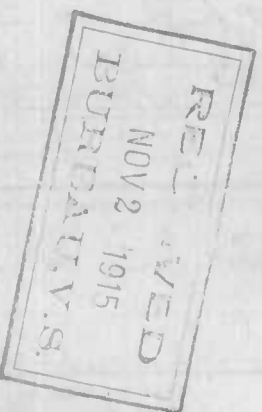
[Approved by U. S. Census and American Public Health
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

County Carroll

17458

(66)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 80

Village or City

New Windsor Church

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Armit M. Speakman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word)Single

6 DATE OF BIRTH

May 24, 1849
(Month) (Day) (Year)

7 AGE

71 yrs. 4 mos. 25 ds.If LESS than
1 day: hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Chester Co. Pa.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Hannah Walter

13 BIRTHPLACE OF MOTHER

(State or country)

Chester Co. Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. James Fraser

(Address)

New Windsor Md.

15

Filed 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 19, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Oct 18, 1915, to Oct 19, 1915,that I last saw her alive on Oct 19, 1915,and that death occurred on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH * was as follows:

Paralysis (Hemiplegia)(Duration) 6 yrs. 0 mos. 0 ds.

Contributory

Secondary

No important complicationsNo previous apparent cause (Duration) 0 yrs. 0 mos. 0 ds.

(Signed)

E. H. Brown

M. O.

Oct 22, 1915 (Address) New Windsor Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

In the

of death 0 yrs. 0 mos. 0 ds.State, 0 yrs. 0 mos. 0 ds.Where was disease contracted,
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kenneth Square Pa. 10/23, 1915

20 UNDERTAKER

ADDRESS

H. B. Burkard & Son Westminister Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*. *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, menin-

ges, peritonaeum, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

NOV 2 1915

BUREAU OF VITALS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Carroll 17459 (61)

Village or City Lylesville (No. Springfield Hospital St. Ward) Registration Dist. No. 74

2 FULL NAME Malliam Henry Tribbitt

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>married</u>
6 DATE OF BIRTH <u>Unknown</u> , 1876 (Month) (Day) (Year)		
7 AGE <u>39</u> yrs. — mos. — ds.		If LESS than 1 day... hrs. OR min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry business, or establishment in which employed (or employer) —		
9 BIRTHPLACE (State or country) <u>Caroline Co.</u>		
PARENTS	10 NAME OF FATHER <u>Unknown</u>	
	11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>	
	12 MAIDEN NAME OF MOTHER <u>Unknown</u>	
	13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Springfield State Hospital Records
(Address) Lylesville, Carroll Co. Md.

15 Filed Oct. 24, 1915 H. H. T. Tribbitt
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 23rd, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 26th, 1915, to October 23rd, 1915, that I last saw him alive on October 23rd, 1915, and that death occurred on the date stated above, at 11:00 P. m.

The CAUSE OF DEATH * was as follows:
General Paresis
(Duration) Unknown yrs. mos. ds.

Contributory —
Secondary

(Signed) John Norfolk Morris, M. D.
Oct. 24th, 1915 (Address) S.S. Hospital Lylesville Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 2 yrs. — mos. 24 ds. In the State, 39 yrs. — mos. — ds.

Where was disease contracted, Caroline Co. Md.
If not at place of death?
Former or usual residence Caroline Co. Md.

19 PLACE OF BURIAL OR REMOVAL <u>Baltimore City</u>	DATE OF BURIAL <u>Oct. 24th</u> , 191 <u>5</u>
20 UNDERTAKER <u>Geo. B. Weer</u>	ADDRESS <u>Lykensville</u>

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

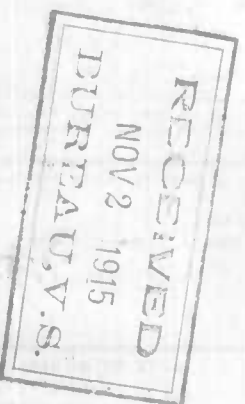
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plowman*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Trocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Painter," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, STRUCK, or HOMICIDE, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *telanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Carroll

17460

1217

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 76Village or City Westminster (No. 170) Church St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John Henry Wilhite

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED, Married
WIDOWED
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

March 27, 1850
(Month) (Day) (Year)

7 AGE

65 yrs. 7 mos. 14 ds.If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of workLaborer(b) General nature of industry
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

Carroll10 NAME OF
FATHERSamuel Wilhite11 BIRTHPLACE
OF FATHER

(State or country)

Carroll12 MAIDEN NAME
OF MOTHERJulia Lerner13 BIRTHPLACE
OF MOTHER

(State or country)

Carroll

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lila Ann Wilhite

(Address)

Westminster Md

15

Filed

Oct-16th 1915 E. H. Shriver

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 14, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Sept 1st, 1915, to Oct 14th, 1915,
that I last saw him alive on Oct 14th, 1915,
and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH * was as follows:

Chronic Nephritis(Duration) 2 yrs. mos. ds.

Contributory

Secondary

(Duration) yrs. mos. ds.(Signed) Chas R. Fout, M. D.Oct 15, 1915 (Address) Westminster*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,
SUICIDAL or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)At place
of death yrs. mos. ds.In the
State, yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Westminster cemeteryOct 17th, 1915

20 UNDERTAKER

ADDRESS

H. Bankard & SonWestminster

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

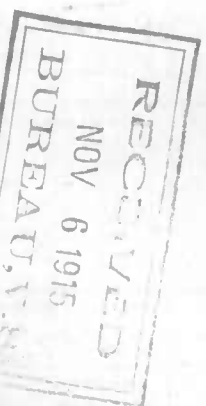
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ges, peritonaeum, etc., *Coronemia*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "Ashenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tranmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reeher wound of hand—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Carroll</u> (17461) (1218)		STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>74</u>	
Village or City <u>Westminster</u> (No. _____)		St. _____ Ward _____	
2 FULL NAME <u>Michael Gugling</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>widower</u>	
6 DATE OF BIRTH <u>Jan 13 1882</u> (Month) (Day) (Year)			
7 AGE <u>83</u> yrs. <u>7</u> mos. <u>3</u> ds.		11 LESS than 1 day.....hrs. OR.....min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Retired</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____			
9 BIRTHPLACE (State or country) <u>Carroll Co Md</u>			
PARENTS	10 NAME OF FATHER <u>David Gugling</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Carroll Co Md</u>		
	12 MAIDEN NAME OF MOTHER <u>Went Know</u>		
	13 BIRTHPLACE OF MOTHER (State or country) _____		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John Gugling</u> (Address) <u>Westminster Md</u>			
15 Filed <u>Oct-19</u> , 191 <u>5</u> <u>E. W. Shriver</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>October 16</u> , 191 <u>5</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>August 1st</u> , 191 <u>5</u> , to <u>Oct 16</u> , 191 <u>5</u> , that I last saw him alive on <u>Oct 16</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>11 P.</u> m. The CAUSE OF DEATH* was as follows: <u>Enlarged Prostate Glands</u>			
(Duration) _____ yrs. <u>2</u> mos. <u>16</u> ds.			
Contributory (Secondary) <u>Retention of urine</u>			
(Duration) _____ yrs. <u>2</u> mos. _____ ds.			
(Signed) <u>John H. Starnes</u> , M. D. <u>Oct 17</u> , 191 <u>5</u> (Address) <u>Westminster Md</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>Backman's Cem</u>		DATE OF BURIAL <u>Oct 19</u> , 191 <u>5</u>	
20 UNDERTAKER <u>James M. Shover</u>		ADDRESS <u>Westminster</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

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